STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	IL6012678	A. BUILDING: _____ B. WING _____	C 11/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESENCE VILLA FRANCISCAN	210 NORTH SPRINGFIELD AVENUE JOLIET, IL 60435

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S9999	Final Observations Statement of Licensure Violations 300.610a) 300.1210b) 300.1210d)2)3) 300.1210d)6) 300.3240a) Section 300.610 Resident Care Policies a) The facility shall have written policies and procedures governing all services provided by the facility. The written policies and procedures shall be formulated by a Resident Care Policy Committee consisting of at least the administrator, the advisory physician or the medical advisory committee, and representatives of nursing and other services in the facility. The policies shall comply with the Act and this Part. The written policies shall be followed in operating the facility and shall be reviewed at least annually by this committee, documented by written, signed and dated minutes of the meeting. Section 300.1210 General Requirements for Nursing and Personal Care b) The facility shall provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychological well-being of the resident, in accordance with each resident's comprehensive resident care plan. Adequate and properly supervised nursing care and personal care shall be provided to each resident to meet the total nursing and personal care needs of the resident. Section 300.1210 General Requirements for Nursing and Personal Care	S9999	Attachment A Statement of Licensure Violations	

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S9999	Continued From page 1 d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 2) All treatments and procedures shall be administered as ordered by the physician. 3) Objective observations of changes in a resident's condition, including mental and emotional changes, as a means for analyzing and determining care required and the need for further medical evaluation and treatment shall be made by nursing staff and recorded in the resident's medical record. Section 300.1210 General Requirements for Nursing and Personal Care d) Pursuant to subsection (a), general nursing care shall include, at a minimum, the following and shall be practiced on a 24-hour, seven-day-a-week basis: 6) All necessary precautions shall be taken to assure that the residents' environment remains as free of accident hazards as possible. All nursing personnel shall evaluate residents to see that each resident receives adequate supervision and assistance to prevent accidents. Section 300.3240 Abuse and Neglect a) An owner, licensee, administrator, employee or agent of a facility shall not abuse or neglect a resident. These Regulations were not met as evidenced by: Based interview and record review the facility failed to assess, monitor, protect and document	S9999		

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S9999	Continued From page 2	S9999		

findings for a Implanted Vascular Access Device. This resulted in R1 being hospitalized with bruising, swelling and pain. R1 had surgery to stop bleeding from blood vessels torn at the site of the device.
This applied to one resident (R1) out of three reviewed for resident injury, neglect and transfers.
The findings include:
R1 was admitted to the facility November 11, 2009 and readmitted on September 2, 2015 per the admission face sheet.
The current Physician order sheet showed R1 had diagnoses of Myelodysplastic Syndrome, Gout, Heart Failure and Urinary tract infection.
R1's admission assessment dated September 2, 2015 showed R1 had an implanted port on the left side of the chest. The assessment showed the port was accessed and dressing changed on August 31, 2015. The nursing note dated September 2, 2015 showed R1 had a port on the left side of the chest that was accessed and changed on August 31, 2015. The note lacks any description of the site or how it is accessed. The note does not show if the access was working and had a blood return.
The Physician Order Sheet showed the Physician had ordered Vancomycin every 12 hours and Azactam every eight hours (both antibiotics) to be given via the Access Device. The Physician also ordered for the dressing of the access device to be changed every Sunday.
The care plan in R1's clinical record showed the staff were to measure intake and output for the duration of fluids. The staff were to administer Intravenous medications as ordered, protect the access device from injury, monitor the insertion access site, change the dressing to the insertion site as ordered and to change Intravenous tubing as directed.

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S9999	Continued From page 3	S9999		

R1's clinical record lacked a Medication Administration Record or a Treatment Administration Record showing the assessment and care of the access device and site.
R1's clinical record lacked consistent documentation of the site or its use. A nursing note dated September 3, 2015 at 6:37 AM, 10:58 AM showed the access was used and remained intact. The next note describing the use of the access was on September 9, 2015 at 1:15 AM. The note does not mention the site only the use of the device. There was no document showing the use of the device or an assessment of the site. The clinical record had no documentation to show a dressing/needle change was done.
An incident report September 10, 2015 showed the facility received a call from R1's daughter while at an appointment with the Physician. R1's family told the facility R1 was being admitted to the hospital for a bruise on her left breast and chest. The report showed staff interviewed was able to use the port on September 9, 2015 during the 2:00 to 10:30 PM shift. R13 Registered Nurse reported the device was used and there was a positive blood return.
On November 12, 2015 at 1:00 PM Z1 Medical Doctor stated R1 came to his office from the nursing home with a large bruise and swelling on the left breast and chest. Z1 said blood vessels were torn and caused bleeding into the lower chest and breast area. Z1 said the area was very painful for R1.
Records from the community hospital showed attending notes by Z2 an assessment that, " The blood was probably leaking from the trauma related to the manipulation of the access device that happened when R1 was pulled. " The note also describes R1 as having severe tenderness to the area.
On November 10, 2015 at 2:36 PM E11 CNA

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S9999	Continued From page 4 (Certified Nursing Assistant) said R1 did complain of pain to her arm. E11 pointed to the left side and said that was the side the arm was hurting. E11 cared for R1 on September 9, 2015 on the afternoon shift. On November 10, 2015 at 2:47 PM, E12 CNA said via telephone that care was provided to R1 on September 10, 2015 in the morning. " R1 had so much pain in her arm I could not finish dressing R1. I went and got E17 registered nurse. " On November 12, 2015 at 11:45 PM E9 LPN (Licensed Practical Nurse) said on September 8 R1 complained of pain to the left arm. E9 gave R1 pain medication. E9 said there was no bruise at that time. E9 stated, " The resident told me the arm was hurting from the aides lifting her under the arms. " There is no documentation of any assessments for these complaints made by R1 in R1's clinical record. Care plans for Intravenous Therapy in R1's clinical record dated September 2, 2015 showed the staff were to monitor the insertion access site and protect from injury. (B)	S9999		